

Michigan Department of Community Health
Bureau of Health Professions
MAPS Program
P.O. Box 30202
Lansing, MI 48909
(517) 373-1737

MAPS REQUEST FOR WAIVER FROM ELECTRONIC FILING

By completing and submitting this application you are indicating that you will be dispensing controlled substances, other than samples, from this location. Only prescriptions dispensed (patient leaving with medication in container), not administered or prescribed, will need to be reported. **This waiver only applies to the individual who has signed this application. Each licensee in a group practice must complete his or her own waiver form.**

The requirements to submit in paper form are as follows: Cannot submit electronic claims in the ASAP format; do not have access to connect to the Internet; do not have access to a compatible personal computer. If you do not have the capability to report this information electronically via the American Society for Automation in Pharmacy (ASAP) format, or directly using a Windows-based program provided by GC Services, a waiver *may* be granted allowing you to submit this information by paper form. An inspection may be required.

To obtain a MAPS Request for Waiver:

You may print the *MAPS Request for Waiver* from our website at www.michigan.gov/healthlicense, under the *Spotlight* section click on Michigan Automated Prescription System, then scroll to the bottom of the page to the *Information* box. You may also request a waiver in writing to the address above and a form will be mailed to you. If you have questions in regards to the application process, you can e-mail questions to MAPSINFO@michigan.gov, or call our office during normal business hours.

Eligibility: MUST have all of the following:

- Professional License
- Controlled Substance License
- Drug Enforcement Administration (DEA) Registration
- Drug Control License (Exempt for samples or veterinarians)

NOTE: Each time a controlled substance is dispensed, including refills, a MAPS Claim Form shall be completed and submitted by the 15th of the following month to GC Services, contractor for the State of Michigan.

A draft of the *MAPS Claim Form* is included as Page #3 of this document. You **must** have this application notarized and completed before returning it to the address listed on the letterhead. Please allow a **minimum** of two weeks for your application to be processed. You will be notified by mail of the decision. Please complete the following:

REQUEST FOR WAIVER APPLICATION

Please Print:

Licensee Name: _____ License #: _____

Address where controlled substances shall be dispensed: _____

DEA #: _____

Do you have the ability to submit prescription information using the ASAP format? ☐ Yes ☐ No

Do you have access to a computer at work or at home for claims submission? ☐ Yes ☐ No

Do you have the ability to connect to the Internet either at work or at home? ☐ Yes ☐ No

What is the estimated **monthly** volume of controlled substance prescriptions dispensed from this location?

Licensee Signature: _____ Date: _____

Office Contact Person: _____ Phone: _____

Subscribed and sworn to before me this _____ day of _____, 20 ____.

Notary Public

My Commission expires: _____

_____ County, State of Michigan.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Authority: P.A. 231 of 2001

Completion: Voluntary

For CIS office use only:

After review of this request, the *Waiver* has been:

☐ **APPROVED** ☐ **APPROVED WITH STIPULATION OF FUTURE INSPECTION**

☐ **DENIED** Inspected By: _____ Date: _____

Authorized Signature _____ Date: _____

DRAFT

Dispenser:		Michigan Automated Prescription System MAPS Claim Form		Patient:	
DEA Number:		Patient ID:		Birth Date (human)	
Name:		Patient (or Animal owner) First Name: Last Name:			
Addr:		Addr:			
City:		State:		ZIP	
First prescription for Patient <input type="checkbox"/>		OR first substance of compounded prescription <input type="checkbox"/>			
Date Written	Prescriber DEA	DEA Suffix			
Date Filled	Rx Number				
Second prescription for Patient <input type="checkbox"/>		OR second substance of compounded prescription <input type="checkbox"/>			
Date Written	Prescriber DEA	DEA Suffix			
Date Filled	Rx Number				
Third prescription for Patient <input type="checkbox"/>		OR third substance of compounded prescription <input type="checkbox"/>			
Date Written	Prescriber DEA	DEA Suffix			
Date Filled	Rx Number				
NDC		Quantity			
Refill Number	Days Supply				
NDC		Quantity			
Refill Number	Days Supply				
NDC		Quantity			
Refill Number	Days Supply				

Dispenser: Transmit electronically in ASAP format, or mail original by 15th of the month to:
G. C. Services, 5015 S. Cedar Suite #230, Lansing, MI 48909 Authority: P.A. 231 of 2001

MAPS - Form 001 - 1A - 12/02

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